

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 22 September 2005

In the Matter of:

GARLAND STREET,
Claimant

Case No.: 2000-BLA-393

v.

APACHE COAL CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Joseph Wolfe, Esq.
Wolfe, Williams & Rutherford
Norton, Virginia
For the Claimant

Laura Metcoff Klaus, Esq.
Greenburg Traurig
Washington, D.C.
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER ON REMAND DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. (the "Act"). The matter is before me on remand from the Benefits Review Board ("BRB" or "Board"). In a Decision and Order dated January 30, 2004, the Board instructed me to "reconsider the medical evidence and determine if claimant suffers from a totally disabling respiratory or pulmonary impairment," Decision and Order at 4, the basis for my conclusion that Mr. Street had established a change in conditions; and re-weigh the medical opinions on causation of disability, Decision and Order at 4-6.

PROCEDURAL HISTORY

The Claimant filed his initial claim for benefits on April 29, 1993. DX 29-1. On October 8, 1993, the District Director of the Office of Worker's Compensation Program ("OWCP") denied the claim stating that the evidence failed to show that the Claimant had pneumoconiosis. DX 29-29.

Less than one year later, the Claimant filed a request for modification. Although the District Director allowed the Claimant to submit additional evidence in support of his request, the Claimant failed to do so, and his request for modification was therefore denied on April 29, 1994. DX 29-37, 38.

On April 17, 1995, the Claimant filed a second request for modification. On April 8, 1996, the District Director denied the Claimant's request for modification. DX 29-50. The Claimant filed a timely appeal and requested a hearing. DX 29-53. The claim was referred to the Office of Administrative Law Judges for hearing on June 13, 1996. DX 29-59. A formal hearing was held on October 16, 1996 before Administrative Law Judge ("ALJ") Frederick D. Neusner. In a Decision and Order dated February 13, 1997, ALJ Neusner concluded:

While the Claimant has sustained his burden of proof under 20 CFR § 718.202 [Determining the existence of pneumoconiosis], (1) he did not demonstrate his total disability under the criteria of 20 CFR § 718.204(c) [Criteria for establishing total disability], and (2) he failed to prove the causal connection required by 20 CFR § 718.204(b) [Pneumoconiosis prevents the miner from performing work], both of which are critical elements in the proof of his entitlement to black lung disability benefits. . . .

DX 29-65 at 7. Accordingly, ALJ Neusner denied benefits.

On March 12, 1999, the Claimant filed a duplicate claim for benefits under the Act. DX 1. On December 7, 1999, the District Director determined that the Claimant was entitled to benefits. DX 23. By letter dated December 14, 1999, the Employer informed the District Director that it disagreed with the determination of Claimant's eligibility for benefits and requested a hearing before the Office of Administrative Law Judges. DX 25. The claim was referred to the Office of Administrative Law Judges on January 27, 2000. DX 31.

After conducting a hearing on this claim in Abingdon, Virginia, I issued a Decision and Order, dated December 13, 2002, in which I awarded the Claimant benefits. Specifically, I concluded first that the Claimant had proven a material change in condition with regard to the issue of total disability, and second that, upon consideration of all the evidence in the record, the Claimant had established his entitlement to benefits.

On January 13, 2003, the Employer appealed my December 13, 2002 Decision and Order. In a Decision and Order dated January 30, 2004, the Board affirmed in part, vacated in part, and remanded the case for further consideration in accordance with the Board's decision.

On April 16, 2004, I issued an order to the parties to confer and file a proposed schedule for further proceedings, or, in the alternative, status reports. By letter dated May 4, 2004, Claimant requested that I issue a briefing schedule and render a decision based on the record. On May 18, 2004, the Employer filed a Status Report and Request for Discovery, seeking to reopen the record to permit it an opportunity to submit proof and be heard on the question of progression in Mr. Street's case. In an Order dated June 23, 2004, I ruled that the Employer's request to conduct discovery so as to reopen the record to submit additional proof was beyond the scope of the remand. I therefore found that the request for discovery should be denied, and that the Claimant's request for a briefing schedule should be granted. The parties were afforded time to file briefs and reply briefs in support of their positions.

On July 23, 2004, counsel for the Employer filed a Remand Brief on behalf of Apache Coal Company and Old Republic Insurance Company. The Claimant failed to submit a Remand Brief.

ISSUES ON REMAND

A. MATERIAL CHANGE IN CONDITION BASED ON A FINDING OF TOTAL RESPIRATORY DISABILITY

The first issue before me on remand involves my finding that the Claimant established a material change in condition pursuant to Section 725.309(d) based on recent blood gas studies, which I held established a totally disabling respiratory or pulmonary impairment pursuant to Section 718.204(b). In my December 13, 2002 Decision, as a point of departure, I cited ALJ Neusner's reasons for finding no entitlement to benefits. Specifically, ALJ Neusner had held that, while the Claimant successfully proved the existence of pneumoconiosis and total disability due to lung cancer, he failed to prove total disability of a respiratory or pulmonary nature and further failed to prove that the disability was caused by pneumoconiosis. In short, ALJ Neusner found that the Claimant failed to prove two elements of entitlement: (1) total disability of a respiratory or pulmonary nature; and (2) that his disability was caused by pneumoconiosis. Accordingly, in evaluating Mr. Street's duplicate claim, the threshold issue before me was whether the Claimant could establish a material change in condition with regard to either of these two elements of entitlement. On that issue, I concluded that the Claimant had proven a material change in condition with regard to establishing a total respiratory or pulmonary impairment, since recent arterial blood gas studies showed a respiratory disability as defined by the regulations. As a result, I determined that I would consider all of the medical evidence of record.

Regarding that aspect of my December 13, 2002 Decision, the Board held that, notwithstanding the qualifying blood gas studies suggesting a total respiratory or pulmonary impairment, I must consider these studies "along with the other relevant and probative evidence, such as the pulmonary function study evidence and medical opinion evidence in order to establish total disability." Slip. op. at 4 *citing* Employer's Brief at 21; *see Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989)(en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 BLR 1-231 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195 (1986); *Gee v. W.G. Moore & Sons*, 9 BLR 1-4 (1986). The Board articulated that, since I did not render a finding based upon all of the relevant newly

submitted evidence, my finding of total disability, as well as my finding of a material change in condition, would be vacated and remanded for reconsideration.

The Employer posits several arguments in its Remand Brief to assert that the Claimant failed to establish a threshold showing of a material change in condition. The Employer's first line of argument, however, relies on a different interpretation of ALJ Neusner's Decision than mine. The Employer interprets ALJ Neusner's Decision as having found the Claimant totally disabled from a respiratory or pulmonary standpoint. *See* Employer's Remand Brief at 17 *citing* slip op. at 7. This leads the Employer to the conclusion that ALJ Neusner denied the claim on the basis of one element of entitlement only: total disability due to pneumoconiosis. *See* Employer's Remand Brief at 17-18. However, in my original decision, I interpreted ALJ Neusner's opinion to mean that the Claimant had failed to establish that he had a total pulmonary or respiratory disability. The Board let stand my interpretation of his opinion in that regard. The Board wrote:

In finding a material change in conditions established since the previous denial, the administrative law judge noted that Administrative Law Judge Frederick D. Neusner previously determined that the existence of pneumoconiosis was established, as well as total disability due to lung cancer, but that the evidence failed to establish a totally disabling respiratory or pulmonary impairment or that the disability was caused by pneumoconiosis.

Slip. op. at 4 *citing* Decision and Order at 6-7; Director's Exhibit 29-65. Although the Board vacated and remanded my findings as to whether the Claimant did indeed establish a total respiratory or pulmonary impairment, it did not disturb my underlying premise that total respiratory disability was an element of entitlement previously adjudicated against the Claimant, and therefore relevant to the issue of material change in condition. In fact, the Board's very instructions are for me to, among other things, "reconsider the medical evidence and determine if claimant suffers from a totally disabling respiratory or pulmonary impairment." Decision and Order at 4. Thus, I reject the Employer's argument that total respiratory disability is irrelevant to the issue of material change in condition, and will now reconsider whether the Claimant did indeed establish a total respiratory disability. As instructed by the Board, I will consider again the blood gas studies, the pulmonary function tests, and the medical opinions, weighing all of the evidence on this issue together.

The blood gas studies showed the following results:

Exhibit Number	Date	Physician	PCO ₂ at rest/ exercise	PCO ₂ at rest/ exercise	Qualifying	Physical Impression
DX 29-22	06/08/93	Forehand	35 33	63 78	Yes No	Mild hypoxemia. No change with exercise. Dr. Michos, DX 29-23, stated valid.
DX 29-49, DX 29-41	02/01/94	Hospital	33.1	72.6	No	
DX 29-49, DX 29-41	03/01/94	Iosif	33.1	72.6	No	Hypoxemia.
DX 29-49, DX 29-41	03/01/94	Hospital	46.5	74.5	No	
DX 29-49, DX 29-41	03/03/94	Hospital	34.8	64.6	Yes	
DX 29-48, DX 29-63	10/18/95	Castle	33.64	77.7	No	Normal.
DX 8	05/17/99	Rasmussen	32 28	72 59	No Yes	Minimal impairment in oxygen transfer at rest.
CX 4, 6	05/03/00	Forehand	30.0 26.0	64.0 69.0	Yes Yes	Evidence of arterial hypoxemia.
EX 4	06/28/00	Castle	36	67.2	No	Mild degree of hypoxemia

In its Remand Brief, the Employer challenges the probative value of the Claimant's arterial blood gas evidence, alleging that in both the original and duplicate claims, the Claimant's blood gas tests produced "mixed results so ... the fact that the [blood gas] tests in the duplicate claim showed more of the same hardly constitutes a finding of a material change." *See* Employer's Remand Brief at 18. However, simply stating that the Claimant's blood gas tests in both the original and duplicate claims produced "mixed results", without addressing the significance of resting versus exercise tests or the sequence of those results, is not particularly persuasive.

As I noted in my December 13, 2002 Decision, two of the three most recent arterial blood gas studies produced qualifying values after exercise; the third, by Dr. Castle, did not include an

exercise study. *See* December 13, 2002 Decision at 14. One of those, which produced qualifying values both at rest and after exercise, was administered within two months of the negative resting test administered by Dr. Castle. *See* December 13, 2002 Decision at 14. While exercise studies are not required if medically contraindicated, Dr. Castle never explained why he did not administer an exercise test. *See* December 13, 2002 Decision at 14. Despite that omission, Dr. Castle specifically observed that the Claimant had developed evidence of hypoxemia with exercise. EX 4:8. Thus I am still of the opinion that the blood gas studies meet the requirements of 20 CFR § 718.204(b)(2)(ii).

The pulmonary function studies showed the following results:

Ex. No. Date Physician	Age Height	FEV ₁ Pre-/ Post	FVC Pre-/ Post	FEV ₁ / FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 29-16 06/08/93 Forehand	38 66"	.75 1.05	.81 1.13		23 23	Yes Yes	Effort submaximal. Uninterpretable but raises possibility of obstruction. Dr. Michos, DX 29-23, said invalid due to poor effort.
DX 29-49 DX 29-41 03/01/94 Iosif	39 66"	.57	1.54			Yes	Invalid due to inconsistent and submaximal effort, cannot be interpreted.
DX 29-48 10/18/95 Castle	41 64"	2.34 2.35	2.84 3.11	82% 84%	35 42	No No	Invalid except for post bronchodilators. Normal. No significant obstruction, no restriction.
DX 6 05/17/99 Rasmussen	44 65"	2.82	4.78	59%	58	No	Minimal obstructive ventilatory impairment. Dr. Michos, DX 9, and Dr. Renn, EX 7, said study is valid.

Ex. No. Date Physician	Age Height	FEV ₁ Pre-/ Post	FVC Pre-/ Post	FEV ₁ / FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
CX 5 05/03/00 Forehand	45 65"	1.35 2.28	1.51 2.96	90% 77%	23	Yes No	Partially reversible obstructive ventilatory pattern. Dr. Renn, EX 8, and Dr. Castle, EX 9, said study is invalid.
EX 4 06/28/00 Castle	45 66" ¹	1.56 1.96	2.41 2.80	65% 70%	43	Yes No	Invalid due to less than maximal effort. Dr. Renn, EX 5, concurred.

In my December 13, 2002 Decision, I concluded that the pulmonary function studies failed to establish a total pulmonary disability within the meaning of the rule, since the only valid pulmonary function test submitted in connection with this claim, taken May 17, 1999, did not produce a qualifying value pursuant to 20 CFR § 718.204(b)(2)(i). I remain committed to that conclusion here as well. I also note that, in its Remand Brief, the Employer reaches a similar conclusion: "[W]hatever impairment was disclosed on the blood gas tests did not affect Street's pulmonary function studies." *See* Employer's Remand Brief at 18.

The record also contains the following relevant medical opinions on the issue of pulmonary or respiratory disability.

Dr. D. L. Rasmussen examined the Claimant on behalf of the Director on May 17, 1999. Dr. Rasmussen's specialty qualifications are not in the file. He took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. Dr. Rasmussen's pulmonary function studies are the only valid studies available in the record for this claim. With regard to the issue of a totally disabling respiratory or pulmonary impairment, the commentary provided by Dr. Rasmussen in his May 17, 1999 medical report states as follows:

LABORATORY STUDIES: Ventilatory function studies revealed minimal obstructive insufficiency. Maximum breathing capacity was markedly reduced, however, it was less

¹ The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there was a variance of 2" in the recorded height of the miner, I took the average height (65.3") in determining whether the studies qualified to show disability under the regulations.

than the calculated value of 113 L/min. The single breath carbon monoxide diffusing capacity and the DL/VA were markedly reduced.

There was minimal impairment in oxygen transfer at rest.

The patient underwent an incremental treadmill exercise study beginning at 2.5 mph at a 0% grade. This level was maintained for 3 minutes. Thereafter, the grade of the treadmill was increased 2.5% per minute. The patient exercised however for only 6 minutes and reached a maximum of 2.5 mph at a 7.5% grade. He achieved an oxygen consumption of 23.2 cc/kg/min, which is excessive for this exercise level. It amounted to some 52% of his weight adjusted predicted maximum oxygen uptake. He denied chest pain. His EKG and blood pressure responses were normal. His anaerobic threshold was not identified at this exercise level. His heart rate was minimally to moderately excessive. His volume of ventilation was very markedly increased. He did retain a breathing reserve of 40 L/min. however. There was marked increase in VD/VT ration and marked impairment in oxygen transfer and he was significantly hypoxic.

DX 7:7. Dr. Rasmussen stated that, overall, Mr. Street's studies indicated "severe loss of pulmonary function." DX 7:7. He further stated that Mr. Street did not retain the pulmonary capacity to perform his last regular coal mine job. DX 7:7.

Dr. J. Randolph Forehand performed a pulmonary evaluation on Mr. Street on May 3, 2000, on behalf of the Claimant. Dr. Forehand is board certified in pediatrics and allergy and immunology. DX 29-19. Dr. Forehand had examined Mr. Street in 1993 for the Department of Labor and diagnosed interstitial lung disease, but could draw no conclusions then as to whether he had a disabling pulmonary impairment because submaximal efforts made his test results uninterpretable. DX 29-17; DX 29-20.

For the May 3, 2000 evaluation, Dr. Forehand took occupational and medical histories, conducted a physical examination, and administered chest x-ray, blood gas and pulmonary function testing. Although the technician observed that Mr. Street's efforts on the pulmonary function tests were variable, Dr. Forehand drew the conclusion that they showed a partially reversible obstructive ventilatory pattern. CX 5. He said that oxygen saturation was abnormal at rest and with exercise. CX 5. Dr. Forehand stated that the Claimant "would be unable to return to his last coal mining job because of the dusty conditions." CX 3:1. As this comment appears in the "History" section of the report, it is unclear whether he was expressing his own or the Claimant's opinion at that point. At the conclusion of the report, he stated as part of his impression that Mr. Street had a "work-limiting respiratory impairment of a mechanical and gas exchange nature." CX 3:3. Although somewhat ambiguously stated, I conclude that Dr. Forehand believed the Claimant to be disabled from his former or similar work.

Dr. James Castle performed a pulmonary evaluation of Mr. Street and reviewed his records on behalf of the Employer on June 28, 2000. He had previously examined the Claimant on behalf of the Employer in 1995, as well as reviewing his medical records, and concluded that Mr. Street was permanently and totally disabled by lung cancer, but not by pneumoconiosis. DX 29-48; DX 29-62; DX 29-64. Dr. Castle is board certified in internal medicine and pulmonary

disease, and a B-reader. EX 6; EX 10. The commentary provided by Dr. Castle in his medical reports focused primarily on what caused the Claimant's disability rather than the nature and extent thereof. At this stage, for purposes of assessing the issue of total respiratory disability only, I shall extract those aspects of Dr. Castle's opinion which speak most directly to that issue.

Upon examination in June 2000, Mr. Street had diminished breath sounds with prolonged expiratory phase. EX 4:3. Spirometry was invalid because of less than maximal effort by Mr. Street. EX 4:3. Resting arterial blood gases showed mild hypoxemia. EX 4:3. Dr. Castle concluded that there was no restrictive impairment, but found mild obstruction induced by smoking. EX 4:7. Dr Castle stated:

It is my opinion that Mr. Street is permanently and totally disabled as a result of pulmonary emphysema due to his previous tobacco smoking habit as well as his history of lung cancer. The fall in his pO₂ with exercise is significant enough to prohibit him from returning to his last coal mining work ...

EX 4:8. Dr. Castle also noted:

It would appear since his previous evaluation in 1995, [that the Claimant] has developed evidence of hypoxemia with exercise.

EX 4:8. After the hearing, in a February 12, 2001 medical report, Dr. Castle reviewed additional medical data. EX 9. His opinions and conclusions remained the same. EX 9:4. He noted that the May 3, 2000, pulmonary function study was invalid and represented less than maximal effort by Mr. Street. EX 9:1-2.

Dr. Joseph E. Renn III conducted several reviews of the Claimant's records on behalf of the Employer. He is board certified in internal medicine with a subspecialty in pulmonary disease, and a B-reader. EX 6; EX 10. His original report dated September 23, 1996, diagnosing centrilobular and bullous emphysema and simple pneumoconiosis, was in the record before ALJ Neusner. DX 29-62.

In a report dated July 10, 2000, Dr. Renn confirmed his prior diagnoses and stated that Mr. Street's ventilatory function had not deteriorated since the 1996 review. EX 3:4. His recent spirometry showed "only a mild obstructive ventilatory defect" and remaining function "adequate to permit heavy manual labor for extended periods of time." EX 3:4. Diffusing capacity and resting gas exchange showed interim improvement. EX 3:4. However, Dr. Renn also noted:

Resting and exercise arterial blood gas tests were performed on May 17, 1999. The resting studies reveal alveolar hyperventilation and normal oxygen tension for his age at the time each was performed. The exercise study reveals alveolar hyperventilation and hypoxemia for his age. In comparison with the resting and exercise studies of June 8, 1993, there has been the interim development of exercise-induced hypoxemia.

EX 3:3. Dr. Renn concluded: "It is my opinion, within a reasonable degree of medical certainty,

that Mr. Street does retain the ventilatory capacity to perform his last known coal mining job of scoop operator or any similar work effort.” EX 3:5.

In a November 16, 2000 report in which he reviewed additional medical data, Dr. Renn stated that the results of Dr. Castle’s June 2000 examination supported his own previous opinions. EX 5:1.

On January 11, 2001, Dr. Renn was deposed. EX 7. He testified that he practices medicine in Morgantown, West Virginia, where he treats patients who have been coal miners. EX 7:3-4. Regarding the issue of total respiratory impairment, Dr. Renn spoke at length about the May 17, 1999 exercise study conducted by Dr. Rasmussen. He noted that this exercise study showed the Claimant to have “attained an oxygen uptake” equivalent to 6.6 METS. EX 7:11-12. According to Dr. Renn, 6.6 METS is in excess of what has been deemed necessary to perform the most strenuous underground coal mine work. EX 7: 12.

In expounding upon this concept, Dr. Renn explained that “an anaerobic threshold is that stage at which we change from adequate oxygen intake to meet the demands of muscle metabolism and we change over to where we go into what’s called oxygen debt.” EX 7:12. In other words, one goes into anaerobic metabolism for the muscles to continue to work. EX 7:12. Dr. Renn explained that this can only be sustained for a short period of time as the muscles will be “starved for oxygen.” EX 7:12. When one goes back to rest, the respiratory system and cardiovascular system “catch up” as oxygen is supplied, “the debt is paid off,” and “everything is back to being stable again.” EX 7:12.

Dr. Renn testified that, because no anaerobic threshold was identified by Dr. Rasmussen during his examination of the Claimant, he believed Dr. Rasmussen “could be saying” that the Claimant did not reach an anaerobic threshold or never went into oxygen debt. EX 7:12. Dr. Renn stated: “In other words, [the Claimant] could perform a large amount of work without incurring that oxygen debt.” EX 7:12. He further stated that Mr. Street’s ventilatory system was supplying the oxygen demanded by his muscles. EX 7:12-13. However, on cross examination, when probed further about his interpretation of Dr. Rasmussen’s medical report, Dr. Renn admitted that he could not comment on Dr. Rasmussen’s remark regarding the anaerobic threshold because he did not truly understand what Dr. Rasmussen was saying. EX 7:18.

Dr. Renn then took issue with Dr. Rasmussen’s remark that it was “excessive” for the Claimant to have achieved an oxygen consumption of 23.2 cc per kilogram per minute at that exercise level. EX 7:18-19. He testified:

Well, you can’t say that because the oxygen consumption is the oxygen consumption is the oxygen consumption. If you measured it, you measured it. And to say that it’s excessive, that’s really not right because what you could be saying when you’re measuring the oxygen consumption is that you’ve found someone who has the ability to take up oxygen more than another person.

EX 7:19.

By way of example, Dr. Renn stated that “if we look at the way ... world-class athletes, are determined, a lot of it is an inherent ability to take up oxygen. And, so, oxygen uptake measurements are done on these athletes; and those that have the ability to take up oxygen best are those that are more likely to become world-class athletes.” EX 7:19.

Dr. Renn admitted that it was a normal response for the pO_2 value of the oxygen tension in the blood to increase rather than decrease during exercise, but he distinguished this phenomenon from his remarks above, stating “oxygen consumption and oxygen tension are two different things.” EX 7:19. Dr. Renn explained that oxygen consumption has to do with “the amount of oxygen that the cells are able to take out of the blood as the blood with the oxygen tension in it passes by them.” EX 7:19. He further stated, therefore, one “can have a reduction of the oxygen tension; but that doesn’t affect the oxygen consumption.” EX 7:19.

On cross examination, Dr. Renn admitted that the Claimant did have some evidence of exercise-induced hypoxemia during Dr. Rasmussen’s examination, the consequence of which was that he would need to “breathe harder in order to keep his oxygen levels up.” EX 7:13. He stated that another implication would be that “he would not be able to do a greater level of work because of a lack of being able to bring in adequate oxygen.” EX 7:13. When questioned directly as to whether he would agree that Dr. Rasmussen’s study represented an abnormal study, Dr. Renn testified that, while the study showed the Claimant to have an exercise-induced hypoxemia, it also showed his ability to exercise to a very considerable level (*i.e.* 6.6 METS). EX 7:20. Dr. Renn stated that the Claimant had a “very good oxygen consumption, which means that he had the inherent ability to take oxygen from the bloodstream and utilize it in the metabolism of the cells.” EX 7:20.

When questioned directly as to whether an individual with a pCO_2 of 28 and a pO_2 of 59 would be able to sustain heavy work throughout an eight-hour period, Dr. Renn testified that the Claimant, in particular, would be able to do so. EX 7:20. He explained that the Claimant’s oxygen uptake shows that, hypothetically, had he had never smoked in his life and never become a coal miner, he could very well have become a “super-class athlete.” EX 7:20.

Dr. Renn admitted that the Claimant was having problems retaining oxygen in the blood as evidenced by the fact that the oxygen tension in the blood reduced significantly during exercise. EX 7:21. However, he then went on to explain the significance of this through a hypothetical example. Dr. Renn posited: Assume that before the Claimant started smoking and destroying his lungs, he started with an oxygen uptake of 40 milliliters per kilogram per minute, *i.e.* higher than the average oxygen uptake of 25 milliliters per kilogram per minute. EX 7:21. In this situation, if both the Claimant and the average person start smoking, the effect of smoking on the average person might mean that they end up on oxygen and in a wheelchair. EX 7:21. However, since the Claimant began with a higher oxygen uptake, he might not reach that same level of incapacitation. EX 7:21.

On cross-examination, Dr. Renn admitted that Dr. Castle did not perform an exercise test. EX 7:21-22. In terms of whether an exercise test would have been helpful, Dr. Renn testified: “Well, it would have told us what the interim situation was and whether or not ... there had been

any progression or regression, either one. I would imagine it's progression since he was continuing to smoke when he saw Dr. Castle." EX 7:22.

In determining how much weight to afford each medical opinion, I must consider the "qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 BLR 2-269 (4th Cir. 1997). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149, 1-155 (1989) (en banc).

As the medical issues of this case are pulmonary and respiratory in nature, Dr. Castle, who is board certified in internal medicine and pulmonary disease, and a B-reader, is particularly well-qualified to provide an opinion. The same is true of Dr. Renn, who is board certified in internal medicine with a subspecialty in pulmonary disease, and a B-reader. Dr. Forehand is less qualified to provide an opinion in that he is board certified in the more attenuated fields of pediatrics, allergy, and immunology. Finally, I cannot address Dr. Rasmussen's specialty qualifications as they are not in the file. While it appears that the opinions of Drs. Castle and Renn deserve the most weight with respect to their qualifications, their opinions are opposite on the issue of disability.

Three of the four physicians who rendered medical opinions in this case found the Claimant to be totally disabled from a respiratory perspective. Dr. Rasmussen stated that, overall, Mr. Street's studies indicate a "severe loss of pulmonary function" and that he did not retain the pulmonary capacity to perform his last regular coal mine job. DX 7:7. As noted above, although it was less than clearly stated, I have also concluded that Dr. Forehand's report articulated an opinion of disability. Dr. Castle expressed a similar belief stating that "the fall in [Mr. Street's] PO₂ with exercise is significant enough to prohibit him from returning to his last coal mining work." EX 4. Dr. Castle even suggested the notion of a material change in condition (or, at least, a change in condition), stating that it would appear, since his previous evaluation in 1995, that the Claimant has developed evidence of hypoxemia with exercise. EX 4:8.

Thus, the only physician who maintained that the Claimant did not have a total respiratory disability was Dr. Renn. In its Remand Brief, the Employer contends that Dr. Renn's opinion deserves great weight, arguing that he was the only physician who "explained in detail the significance of the blood gas tests." See Employer's Remand Brief at 18 citing EX 3:3, 5. While I agree that Dr. Renn provided the lengthiest medical opinion, it is inconsistent with the objective evidence from the arterial blood gas study, and, unlike the other opinions, it was not

based on an examination of the Claimant. Moreover, it appears to be based on equivocal interpretations of Dr. Rasmussen's comments. For example, at first he contended that Dr. Rasmussen "could be saying" the Claimant never reached an anaerobic threshold (EX 7:12), but later admitted, on cross-examination, that he was unsure of how to interpret Dr. Rasmussen's remark (EX 7:18). Moreover, although Dr. Renn appears to base his criticism on the premise that the Claimant's oxygen consumption was inherently "very good," he provided no explanation of how to relate this premise to the exertion required by the job. Additionally, when questioned as to whether the results of Dr. Rasmussen's study were abnormal (*i.e.* whether the study indicated an impairment), Dr. Renn's response was evasive. He merely stated that, while the study showed an exercise-induced hypoxemia, the Claimant nevertheless maintained an ability to exercise to a "very considerable level." Furthermore, when questioned as to whether someone with such results would be able to sustain heavy work throughout an eight-hour period, Dr. Renn returned to his theory that the Claimant, in particular, had an inherent ability to do so. I find that Dr. Renn's opinion is not as well documented or reasoned as those of the other doctors.

In summary, the most recent arterial blood gas exercise studies meet the standard for disability. Although the pulmonary function studies do not meet the standard, they measure a different lung function than the arterial blood gas studies, and, therefore, do not contradict them. Finally, the weight of the medical opinions also supports a finding of respiratory disability. Weighing all of the medical evidence on this issue together, I find that the Claimant has established that he is totally disabled by a respiratory impairment. It follows that he has shown a material change in condition since his previous claim was denied.

B. CAUSATION OF DISABILITY

The second issue before me on remand involves my finding that the medical opinion evidence was sufficient to establish total disability due to pneumoconiosis pursuant to 20 CFR §718.204(c). Slip op. at 5. As noted by the Board, in my December 13, 2002 Decision, I held that the x-ray evidence demonstrated a progression in the Claimant's pneumoconiosis. Slip op. at 5. I gave diminished weight to the opinions of Drs. Castle and Renn, who attributed Claimant's impairment solely to smoking, because in my view, neither physician acknowledged the apparent progression nor explained, in other than conclusory terms, why pneumoconiosis did not contribute to Claimant's impairment. Slip op. at 5. *citing* Decision and Order at 17. I then found that the opinions of Drs. Rasmussen and Forehand, which state that pneumoconiosis did contribute to Claimant's disability, were in better accord with the "evidence underlying their opinions" and the "overall weight of medical evidence in the record." Slip op. at 5. *citing* Decision and Order at 18. I thus found that the preponderance of the medical opinion evidence was sufficient to establish total disability due to pneumoconiosis pursuant to Section 718.204(c). *Id.*

The Employer argued, and the Board agreed, that my reasons for affording diminished weight to the opinions of Drs. Castle and Renn were invalid. Slip op. at 5. Specifically, I gave diminished weight to Dr. Castle's opinion because I found that he disregarded the positive x-ray readings in the record and further made no indication that he had changed his view that simple pneumoconiosis is unlikely to cause disability. Slip op. at 5. The Board held, however, that these factual determinations were not supported by the evidence, finding first that Dr. Castle did

consider both the positive and negative x-ray evidence, and second that he did not necessarily indicate a belief that simple pneumoconiosis was unlikely to cause disability. Slip op. at 6. With regard to the opinion of Dr. Renn, I gave it diminished weight because Dr. Renn failed to diagnose a totally disabling respiratory impairment when I had found such an impairment to be present. Slip op. at 6. However, since my finding regarding total disability was remanded, the Board held that my analysis of Dr. Renn's opinion must likewise be remanded. Slip op. at 6. Additionally, the Board held that I must reweigh all of the medical opinion evidence, including the opinions of Drs. Rasmussen and Forehand, in accordance with the standards of the Fourth Circuit, which require an assessment of "the qualifications of the respective physicians, the explanation of their medical opinions, the documentation underlying their medical judgments, and the sophistication and bases of their diagnoses." *Sterling Smokeless Coal Co. v. Akers*, 131 F.3d 438, 21 BLR 2-269 (4th Cir. 1997).

I will address the four medical opinions again, this time focusing on the doctors' views regarding causation of disability.

As noted previously, Dr. Rasmussen examined Mr. Street on behalf of the Director on May 17, 1999. With regard to the cause of the Claimant's impairment, Dr. Rasmussen wrote:

The three apparent risk factors are his cigarette smoking, his right upper lobectomy and his coal mine dust exposure. The latter is the primary cause of his impairment in view of the pattern of marked impairment in oxygen transfer [sic] and only minimal obstructive ventilatory impairment and no restrictive lung disease.

I do not know if he received chemotherapy or radiation therapy following his right upper lobectomy. These agents, particularly the radiation, could produce lung damage.

DX 7:4.

Upon re-consideration of his opinion, I note that Dr. Forehand did not explicitly address the cause of the Claimant's "work-limiting respiratory impairment." He listed coal workers' pneumoconiosis as his first diagnosis, before a history of carcinoma and status post surgical removal of a portion of the right lung, and, finally, the impairment, from which I infer that he believed that pneumoconiosis was a contributing cause for the impairment. CX 3. Nonetheless, as it is generally unexplained, I now find that his opinion on causation can be given little weight.

As noted previously, Dr. Castle performed a pulmonary evaluation of Mr. Street and reviewed his records on behalf of the Employer on June 28, 2000. He had previously examined the Claimant on behalf of the Employer in 1995, as well as reviewing his medical records, and concluded that Mr. Street had "minimal or sub-radiographic coal workers' pneumoconiosis" which made it "extraordinarily unlikely" to cause him harm. Deposition at p. 13, DX 29-64. He concluded Mr. Street was permanently and totally disabled by lung cancer, but not by pneumoconiosis. DX 29-48; DX 29-62; DX 29-64. In his June 28, 2000 pulmonary evaluation, Dr. Castle opined, after a thorough review of all the data, including medical histories, physical examinations, radiographic reports, pulmonary function tests, arterial blood gases, and other data, including pathology specimens, that Mr. Street did have pathologic evidence of simple coal

workers' pneumoconiosis. EX 4:6. He further stated that Mr. Street "certainly worked in or around the underground coal mines for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host." EX 4:7. Dr. Castle then stated that another risk factor for the development of pulmonary symptoms and disease is that of tobacco abuse, noting that the Claimant had indicated a 14-21 pack year smoking history.² EX 4:7. Dr. Castle stated that at the time of his most recent examination, the Claimant had an elevated carboxyhemoglobin level indicating the presence of carbon monoxide in his blood, such as that seen with tobacco abuse. EX 4:7. Dr. Castle stated that the Claimant "certainly has had an adequate enough exposure to tobacco smoke to have caused him to develop chronic obstructive pulmonary disease, *i.e.* chronic bronchitis/emphysema and/or lung cancer in a susceptible host." EX 4:7. Dr. Castle stated that it was also clear the Claimant had evidence of resection of an adenocarcinoma of the lung in 1994 and that this cancer was related to his tobacco smoking history. EX 4:7. However, according to Dr. Castle, the Claimant did not have a consistent finding of rales, crackles or crepitations, which would indicate the presence of an interstitial pulmonary process such as that seen with significant coal workers' pneumoconiosis. EX 4:7.

Dr. Castle noted that it was his opinion, along with the majority of radiologists and B-readers, that there was no evidence of coal workers' pneumoconiosis radiographically. EX 4:7. Although the Claimant had evidence of increased irregular markings in the lower lung zones, these were not consistent with a diagnosis of coal workers' pneumoconiosis. EX 4:7. Rather, they were consistent with the development of bullous emphysema associated with tobacco abuse. EX 4:7. At the same time, Dr. Castle noted that he did have evidence of pathologic changes consistent with coal workers' pneumoconiosis in the nodular lesion resected from the upper lobe. EX 4:7. Nevertheless, there were no significant abnormalities seen on x-ray, indicating that these changes were quite minimal pathologically. EX 4:7. A review of the older records indicated that the pathology specimen at the time of the Claimant's lung surgery did show evidence of simple coal workers' pneumoconiosis. EX 4:8.

Dr. Castle stated that the most recent physiologic studies done at the time of the Claimant's evaluation were invalid insofar as the spirometry was concerned, stating, nevertheless, that there was no evidence of any restriction. EX 4:7. He noted that Dr. Rasmussen, with a valid spirometry without bronchodilator testing, found evidence of a mild degree of airway obstruction. EX 4:7. These data were well above federal disability standards. EX 4:7. The Claimant did have a reduction in the diffusing capacity. EX 4:7. Dr. Castle stated that when coal workers' pneumoconiosis causes impairment, it does so by causing a mixed, irreversible obstructive and restrictive ventilatory impairment. EX 4:7. The Claimant did not demonstrate any restrictive impairment whatsoever. EX 4:7. Thus, Dr. Castle opined that this mild degree of airway obstruction with a reduced diffusing capacity was due to tobacco smoke induced pulmonary emphysema. EX 4:7. Dr. Castle also noted that the arterial blood gases obtained at the time he examined the Claimant showed a mild degree of hypoxemia at rest. Dr. Rasmussen found essentially normal blood gases at rest with a fall in the pO₂ with exercise. EX 4:8. According to Dr. Castle, this was in keeping with his tobacco smoke induced pulmonary emphysema. EX 4:8.

In sum, for the reasons stated above, Dr. Castle opined that the Claimant did have

² Previously, it had been documented that the Claimant had had at least a 44 pack year smoking history. EX 4:7.

pathologic evidence of simple coal workers' pneumoconiosis; however, he also opined that the Claimant was not permanently and totally disabled as a result of coal workers' pneumoconiosis or as a result of any process arising from his coal mining employment. EX 4:8. Rather, Dr. Castle believed that the Claimant was permanently and totally disabled as a result of pulmonary emphysema due to his previous tobacco smoking habit as well as his history of lung cancer. EX 4:8. While the fall in his pO₂ with exercise was significant enough to prohibit him from returning to his last coal mining work, Dr. Castle felt this to be unrelated to the underlying coal workers' pneumoconiosis. EX 4:8. He further stated that these findings, namely the tobacco smoke induced pulmonary emphysema and lung cancer, were unrelated to his coal mining employment and coal dust exposure. EX 4:8. Dr. Castle noted that it would appear since his previous evaluation in 1995, that the Claimant had developed evidence of hypoxemia with exercise. EX 4:8. However, he believed that this change was related to his underlying tobacco smoke induced bullous emphysema because he had had no further coal dust exposure since 1987. EX 4:8. In addition, he said the Claimant had had no progression of his x-ray since the previous examination, and his pulmonary function studies had either been unchanged or had shown a minimal decline in the diffusing capacity. EX 4:8. These findings were noted in the presence of an elevated carboxyhemoglobin level, which would indicate ongoing tobacco smoke exposure. EX 4:8. Dr. Castle opined that there had been no material change in condition with regard to the pathologic evidence of coal workers' pneumoconiosis. EX 4:8. Nevertheless, at that time, the Claimant did have a disabling respiratory impairment due to tobacco smoke induced pulmonary emphysema and bronchogenic carcinoma of the lung. EX 4:8. Dr. Castle's opinions and conclusions remained the same after reviewing additional medical records after the hearing. EX 9.

In his report dated July 10, 2000, Dr. Renn, like Dr. Castle, attributed the Claimant's development of exercise-induced hypoxemia to tobacco smoke-induced emphysema. Dr. Renn concluded:

... It is my opinion, within a reasonable degree of medical certainty, that the mild degree of simple coal workers' pneumoconiosis present in Mr. Street has neither caused, nor contributed to, his ventilatory dysfunction. It is my opinion, within a reasonable degree of medical certainty, that his respiratory dysfunction has resulted from his tobacco smoke-induced centrilobular and bullous emphysema.

EX 3.

During his deposition, Dr. Renn identified the Claimant's risk factors to include work in underground coal mines, tobacco smoking, a family history of asthma, a history of heart disease, and a history of alcohol abuse, which placed him at risk for certain diseases which could affect the respiratory tract in conjunction with his tobacco smoking. EX 7:7. Dr. Renn went on to testify that the Claimant had centrilobular and bullous pulmonary emphysema related to smoking, and simple coal workers' pneumoconiosis. EX 7:7. He further stated:

[T]he centrilobular emphysema and the bullous emphysema are not related to his coal mine dust exposure. They're related to his tobacco smoking. The centrilobular emphysema is not the type of emphysema associated with coal workers' pneumoconiosis.

Focal emphysema is the type that's associated with coal workers' pneumoconiosis. And the pathological evaluations that have been performed have distinguished the coal workers' pneumoconiosis, or focal emphysema, from that associated with his tobacco smoking; in other words, the centrilobular emphysema and the bullous emphysema.

EX 7:8. Dr. Renn testified that the centrilobular emphysema and bullous emphysema and simple coal workers' pneumoconiosis were two distinct disease processes going on in Mr. Street's case. EX 7:8-9. Dr. Renn testified that he considered the May 1999 pulmonary function test, conducted under Dr. Rasmussen's direction, to be valid, and also noted that it revealed a mild obstruction at that time. EX 7:9-10. Dr. Renn opined that the Claimant's mild obstructive lung disease was a consequence of the bullous and centrilobular emphysema, and that the Claimant's simple coal workers' pneumoconiosis was "too mild to have resulted in any degree of obstruction or significant obstruction." EX 7:10. He stated that the Claimant had "the pattern on the spirometry study of May 17, 1999 that's consistent with tobacco smoking and not consistent with that found in the obstructive airways disease associated with coal workers' pneumoconiosis." EX 7:10. Dr. Renn reiterated his opinion expressed in his report that the cause of the Claimant's exercise-induced hypoxemia was his tobacco smoke-induced centrilobular and bullous emphysema. EX 7:11, 13.

In summary, Dr. Rasmussen and Dr. Forehand, with little explanation, were of the opinion that pneumoconiosis contributed to the Claimant's disability. Although Dr. Castle and Dr. Renn disagreed on the extent of the Claimant's impairment, they agreed that the cause of his impairment was smoking, and not coal workers' pneumoconiosis. The Claimant last worked in the mines in 1987, and the record is compelling that he was still smoking as late as June 2000 when he was examined by Dr. Castle. In their comments, both Dr. Castle and Dr. Renn appear to have focused on medical, or clinical, pneumoconiosis, as opposed to legal, or statutory, pneumoconiosis. *See* 20 CFR § 718.201. Nonetheless, both were unequivocal in their opinions that smoking, and not pneumoconiosis, caused the Claimant's impairment. There is no indication in the record that any physician, including Dr. Rasmussen or Dr. Forehand, was made aware of Dr. Castle's or Dr. Renn's views, or given an opportunity to rebut them. Given Drs. Castle's and Renn's superior qualifications, as well as their much more detailed explanations of their reasoning, I conclude that their opinions must be given greater weight than those of Dr. Rasmussen and Dr. Forehand on the cause of the Claimant's impairment. For this reason, I find that the Claimant has failed to establish that his respiratory disability was caused by pneumoconiosis.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that his respiratory disability was caused by pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

On March 31, 2003, I issued a Supplemental Decision and Order granting a fee to the Claimant's counsel, but holding the fee petition in abeyance until final disposition of the claim.

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim. Absent a successful appeal of this decision, therefore, no fee may be charged.

ORDER

The claim for benefits filed by Garland Street on March 12, 1999, is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 CFR §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 CFR § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 CFR § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 CFR § 725.479(a).